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Between the Lines: A Qualitative Phenomenological Analysis of the Therapeutic Alliance in Pediatric Physical Therapy

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ABSTRACT

Aim: To explore perceptions and preferences of children, parents, and physical therapists regarding the therapeutic alliance in pediatric physical therapy in a rehabilitation setting. **Methods:** Qualitative phenomenological analysis of interviews with children ($n = 10$), their parents ($n = 10$), and physical therapists ($n = 10$). **Results:** Three themes were identified: importance of trust in the physical therapist, transparency in sharing information, and negotiation concerning goals and tasks of treatment. Parents considered trust in the therapist's relational skills of greater importance to the therapeutic alliance than the therapist's technical skills. Although the physical therapists showed a strong willingness to meet the needs of children and parents, they seemed unaware of the emotional impact of positional inequality and the differences in roles and tasks of children, parents, and therapists during the treatment. **Conclusion:** All participants emphasized the importance of the quality of the therapeutic alliance. Nevertheless, positional inequality and differences in roles and tasks appeared to influence negotiation about goals and tasks of treatment. Children and parents are in a dependent relationship with the physical therapist. Physical therapists are challenged to find the right balance between their professional position and input on the one hand, and the emotional needs of child and parents on the other hand.



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Child; parent; physical therapy; qualitative research; rehabilitation; therapeutic relationship

Parents and family are two of the most important environmental factors that influence functioning of children with a disability (Rosenbaum, King, Law, & Evans 1998; Turnbull et al., 2007). Within family-centered care, parents (and family) are regarded as

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unique experts on their child's needs (Rosenbaum et al., 1998). Parents constitute the primary source of strength and support for the child and should be seen as partners in the treatment process. In the context of pediatric physical therapy, it is crucial to develop a collaborative relationship, the therapeutic alliance, between the child, parents, and therapist (Bam & Rosenbaum, 2008; Rosenbaum et al., 1998; MacKean, Thurston, & Scott, 2005).

Rogers (1965) proposed that the core characteristics of a therapist include empathy, congruence, and unconditional positive regard (Rogers, 1965). These characteristics are both necessary and sufficient for effecting therapeutic change in clients (clients refers to both child and parents in pediatric physical therapy) (Bamm & Rosenbaum, 2008). Within any form of therapy, the therapeutic alliance reflects the relationship between client and therapist and includes three factors: (1) agreement between clients and therapist on the goals of the treatment; (2) agreement between clients and therapist on the tasks (to achieve the proposed goals); and (3) quality of the bond between clients and therapist (Bordin, 1979).

A lack of agreement on goals and tasks as well as a lack of therapeutic negotiation may result in ruptures in the therapeutic alliance and drop-out from treatment (Safran & Kraus, 2014). Safran, Muran, & Eubanks-Carter (2011) have defined ruptures as “a tension or breakdown in the collaborative relationship between client and therapist. Ruptures are said to vary in intensity from relatively minor tensions, of which children, parents, and therapists may be only vaguely aware, to major breakdowns in collaboration, understanding, or communication” (Safran et al., 2011). These ruptures (tensions) in the therapeutic alliance are considered standard in the therapeutic process and provide opportunities for changing and strengthening the relationship (Safran & Kraus 2014).

Children, parents, and therapists have different tasks and responsibilities within the context of family-centered care and the therapeutic alliance. The therapist brings communication skills, professional skills, and knowledge into the alliance, together with a perspective on the health condition and treatment of the child. The child brings a care need that is situated in a certain context and is among others shaped by child's personal characteristics. Finally, the parents, as experts on their child, bring their strengths, needs, and values into the alliance (Rosenbaum et al., 1998; Towle, Godolphin, Greenhalgh, & Gambrill, 1999). Treatment requires a closeness of fit between the preferences, personal characteristics, and context of child and parents on the one hand, and the personality and professionalism of the therapist, her/his therapeutic attitude, and the treatment methods applied (techniques) on the other hand (Green, 2006). The position of child, parents, and therapist in the therapeutic alliance is by definition unequal, because the relationship is based on the problem and care need of the child and parents (Bellin, Osteen, Heffernan, Levy, & Snyder-Vogel, 2011; Harrison & Williams, 2000; Fumagalli, Radaelli, Lettieri, Bertele, & Masella, 2015).

There is limited research on the role of the therapeutic alliance in physical therapy (Babatunde, MacDermid, & MacIntyre, 2017; Hall, Ferreira, Maher, Latimer, & Ferreira, 2010). Generally, pediatric physical therapy implies a complex relational situation in which both child and parent(s) are in subordinate position to the physical therapist. Treatment may take place over a long period of time, during which the child is going

through vulnerable developmental phases (Broggi & Sabatelli, 2010; Green, 2006). Therefore, a specific task for the pediatric physical therapist in this context is to encourage the development of a collaborative relationship, taking into account not only the child's needs and developmental stages but also the parents' needs and the parental position throughout the treatment process (Palmer, Cooper, & Bresler, 2001; Piaget, 2005).

Although the principles of family-centered care are widely accepted and considered best practice in pediatric physical therapy, full implementation of these principles in daily practice has proven to be difficult (Bailey, Raspa, & Fox, 2012; Bam & Rosenbaum, 2008). Full implementation of family-centered care is limited by a lack of competence and confidence of the physical therapists (Bam & Rosenbaum, 2008). Developing emotional and social involvement with children and their families requires specific competences, such as the possession of interpersonal communication skills, the ability to address psychosocial issues, and the confidence not to feel threatened by power shifts (Bam & Rosenbaum, 2008; Pinto et al., 2012). Furthermore, recent qualitative studies have demonstrated that both health care professionals and their clients find it difficult to understand the concept of collaboration and its application to clinical practice (Bam & Rosenbaum, 2008). Therefore, there is a need to further explore and explain the concept of the therapeutic alliance in pediatric physical therapy to meet the needs of children and their parents.

This study used a qualitative, phenomenological, interview-based design to explore the opinions, perceptions, and preferences of children, parents, and physical therapists regarding the therapeutic alliance in pediatric physical therapy in a rehabilitation setting.

Methods

Design

This study used a phenomenological approach (Moustakas, 1994). First, the analysis focused on the experiences, thoughts, and emotions of the participants (children, their parents, and physical therapists) regarding the importance of the therapeutic alliance. Second, personal preferences concerning tasks, goals, and attitudes of the participants were explored. This approach was applied to develop a deeper understanding of the characteristics of the therapeutic alliance (Cresswell, 2012; Moustakas, 1994).

Participants

Participants were 10 children, 10 parents, and 10 physical therapists recruited from the Department for Pediatric Rehabilitation of Treant Zorggroep Hospital, Emmen, the Netherlands. The research protocol was approved by the Hospital's Medical Ethics Committee. Children with disabilities who could speak and understand Dutch and had attended at least three treatment sessions with their physical therapists were eligible for inclusion. Heterogeneous sampling was used to select children in pediatric rehabilitation with different ages, types of diagnoses, durations of treatment, and education levels.

Recruitment letters, word-of-mouth recruiting, and email announcements were utilized to invite children and (one of) their parents to participate. When both child and

Table 1. Characteristics of the study participants.

Child	Diagnoses	Age (Years, months)	Parent (age)	Education of parent	Household income	Number of adults at home	Nationality (primary language)	Therapists experience/ age in years
Child 1	Neuromuscular disorder	13,4	Mother (38)	Primary school	Lower income	Single mother	Albania (Albanese)	5/28
Child 2	Cerebral palsy	12,4	Mother (37)	Higher professional education	High income	2 parents	Netherlands (Dutch)	3/27
Child 3	Cerebral palsy	7,3	Mother (33)	Higher professional education	High income	2 parents	Netherlands (Dutch)	22/56
Child 4	Orthopedic problems	13,6	Father (53)	Secondary education	High income	2 parents	Netherlands (Dutch)	20/52
Child 5	Congenital disorder	3,2	Mother (37)	Higher professional education	High income	2 parents	Netherlands (Dutch)	19/54
Child 6	Orthopedic problems	16,2	Mother (42)	Professional education	Modal income	2 parents	Netherlands (Dutch)	12/35
Child 7	Congenital disorder	15,10	Mother (41)	Higher professional education	Modal income	2 parents	Netherlands (Dutch)	7/31
Child 8	Psychomotor retardation	13,4	Mother (38)	Professional education	Modal income	Single mother	Netherlands (Dutch)	4/29
Child 9	Orthopedic problems	17,2	Mother (40)	Professional education	Modal income	2 parents	Netherlands (Dutch)	6/28
Child 10	Psychomotor retardation	16,3	Mother (44)	Professional education	Lower income	Single mother	Netherlands (Dutch)	4/28

Note: age in years (m = months): duration of the treatment by the physical therapist; ad therapist; ad parent (:): age in years: Lower income <28,000, modal income = 28,000–36,000, and high income > 36,000.

parent(s) consented to participate, their physical therapist was subsequently invited to participate in the study. Before data collection, written informed consent was obtained from all participants. Participant characteristics are described in [Table 1](#).

Procedure

The semi-structured interviews were conducted by author A.C. ([Table 2](#)). The interviews were pilot tested in two children, two parents, and two therapists who were not recruited as participants. All interviews were audio recorded. Field notes were made to record first impressions of each interview. The interviewer was not involved in the treatment.

Before data collection, literature on the therapeutic alliance was studied by the authors (A.C. and D.P.). In addition, the author A.C. observed several treatment sessions to become familiar with the interaction between children, parents, and physical therapists. Thoughts and reflections about these sessions were documented.

Interviews were conducted between October 2013 and March 2015. The interviews were performed using the River Model (Evers, 2007). This model entails that open questions concerning a topic are presented as if they were “flowing like a river.” Whenever a topic “runs dry,” the interviewer “flows” back to the “mainstream of the river” (Evers, 2007). Before the interviews, rapport was established with the respondents. Respondents were urged to inform the interviewer if they felt uncomfortable about the interview topics and did not want to answer the questions. The average duration of the interviews was 40 minutes for the children and 60 minutes for the parents and physical therapists.

Table 2. A summary of the topics mentioned in the interview guide.

Interview guide	
Introduction	<p>The interview begins with a general introduction about the purpose of the interview. The interviewer introduces him/herself. The aim is to build a relationship with the participants.</p> <p>The technique of open interviewing will be applied. The interviewer will intervene minimally during the conversation.</p>
Main topics	<p>Experienced therapeutic alliance Family-centered care Triangular relationship Organization of care</p>
Central questions therapists and parent	<p>“What are your ideas / thoughts about therapeutic relationship between child, parent, and therapist? What can you tell me about it?” “Which factors are important for the therapeutic relationship? What are your thoughts about it, and can you give an example?” “What are your experiences with regard to the therapeutic relationship?”</p>
Central questions child	<p>“How important is the therapeutic relationship for you?” “What can you tell me about the relationship with your therapist?” “Are you content with the relationship? If this is the case, can you tell me why? If you are not content, can you explain to me why this is the case?” “How important is the therapeutic relationship for you; can you tell me what you find important?”</p>
Specific questions	<p>“What are your thoughts/feelings about your current therapeutic relationship?” “How did the current therapeutic relationship develop?” “Which factors are important for this specific therapeutic relationship?”</p>

Data Analysis

Audio recordings of the interviews with all participants were transcribed verbatim. The authors (A.C. and D.P.) independently performed an initial data analysis in an iterative process, based on qualitative data analysis for phenomenological research (Moustakas, 1994). This analysis consisted of repeatedly reading the transcripts and listening to the audio recordings until the researchers had become sufficiently familiar with the data. First, significant statements, sentences, and quotes on the concepts of therapeutic alliance and family-centered care were coded. Next, similar codes were grouped into themes and subthemes (Moustakas, 1994). Throughout the data analysis process, the researchers (A.C., D.P., and A.W.) identified themes within the transcripts; explored similarities, differences, and dynamics in the materials and discussed and compared the coding.

New codes and themes were identified throughout the period of data analysis, and data were continuously reexamined. Interviews continued until data saturation was achieved, at which stage no new subthemes emerged from the interviews. Data from interviews, initial observations, and field notes were triangulated as an addition to an iterative consensus coding process. Triangulation between researchers (G.P., P.D., A.C., and D.P.) in consensus meetings was conducted to explore new codes, and review (sub) themes (see Supplemental data Appendix 1). Peer debriefing was performed with a rehabilitation physician (C.M.) who was not involved in the data analysis. This physician evaluated whether the themes remained true to the data and whether the themes were accurately represented during the analysis-synthesis process.

The interviews with two young children (i.e. 4 and 7 years of age) were excluded from the analysis, because the children were unable to clearly articulate their experiences. The interviews with their respective parents and physical therapists were included in the analysis.

Trustworthiness

Multiple strategies were used to promote trustworthiness including multiple coders, and iterative consensus coding process, and triangulation of multiple sources of data across the three types of participants (Moustakas, 1994). Member checking was performed in three children, three parents, and three physical therapists, by providing a verbal summary at the end of the interview and checking whether the participant agreed. All participants confirmed the relevance of the themes and confirmed that the analyses were an accurate reflection of the content of their interviews. Before data collection, as part of bracketing, the interviewer (A.C.) began with a full description of her own experiences, prior knowledge, assumptions, values, and interest to draw awareness to her presumptions regarding the phenomenon therapeutic alliance (Tufford & Newman, 2010). Discussions enabled the researcher to detach herself from these presumptions and set them aside, to direct her focus on the experience of the participants. Finally, triangulation of data collected among children, parents, and physical therapists was performed by analyzing overlap and differences between the three types of participants to understand the underlying relational dynamics.

Results

All participants emphasized the importance of the quality of the therapeutic alliance in pediatric physical therapy. The concept of the therapeutic alliance appeared to be new to the physical therapists, and they were not used to reflecting on this concept. Both children and parents stressed their *need for trust* in the physical therapists and their need for willingness of the physical therapists to take wishes of children and parents into account during therapy (Theme 1). Furthermore, the older children, parents, and physical therapists emphasized the importance of *sharing information* (Theme 2). Finally, all participants repeatedly mentioned the importance of *negotiation* concerning goals and tasks of the treatment (Theme 3).

Theme 1: Need for Trust in the Physical Therapist

Two types of trust were described by children and parents: trust in *relational skills* and trust in *technical skills* of the physical therapist. Parents and children considered the relational skills of the physical therapist to be more important than technical skills. The dependent position of children and parents in relation to the personal and professional qualities of the physical therapist seemed to underlie this need. Moreover, children and parents emphasized their need for trust in the therapist to be able to feel safe. This need to feel safe appeared to be a prerequisite for treatment and can also be related to the implicit and explicit sense of loss of control caused by positional inequality.

Parent 3 [from Child 3]: “Your mom is a safe haven to fall back on. The therapist is also kind of safe haven, he [the child] must feel at ease there.... That is an important condition. My child has 100% trust in his therapist, which is essential for the success of the treatment. He will not immediately trust the therapist fully; trust grows over time. Through experiences he [the child] knows that if something does not work, she [the therapists] will help him for a moment ... if it starts to become difficult, she has a solution that works.”

With regard to trust in the *relational skills* of the physical therapist, parents emphasized the importance of communicating and connecting at the level of the child and offering positive feedback to the child. They also stressed the importance of an open, emphatic, and welcoming attitude of the physical therapists toward the child. Furthermore, they wanted the therapist to create a safe and positive atmosphere in which respectful interaction with the child can take place. Some parents explicitly mentioned that they expected transparency in communication when it came to discussing problems. In addition, they felt that the physical therapist should be able to understand the cognitive and emotional implications of the diagnosis for both child and parents. Other parents mentioned that the physical therapist focused too much on goals related to motor skills, while they experienced much stress and sorrow due to their child's diagnosis. These parents were caught between hope for improvement and fear of decline and stressed the importance of a holistic approach.

Parent 6 [from Child 6]: "In general, I think it is important that the therapist makes you feel welcome and comfortable. For example, by saying: 'Hello, it's nice to see you and we're going to do something funny today.' The therapist should see my child as a whole person and not only focus on my child's problems with motor skills."

Generally, physical therapists agreed with the aforementioned importance of interpersonal skills. They emphasized their willingness to collaborate with child and parents and acknowledged the importance of trust in the therapist as a prerequisite to strengthen the collaboration between them. They also stressed their wish to be perceived as a good professional, which they equated more with *technical skills* than *relational trust*. Children did express a need for feeling safe with regard to contact and communication, they wanted to experience a relaxed atmosphere with room for jokes. Children wanted the therapist to smile a lot and be joyful, but at the same time, they wanted the therapist to be respectful.

Child 4: "I like her. On the one hand she is serious and understands me well, but on the other hand she has a good sense of humor. But if you are having a serious conversation, she should not suddenly start doing weird things. So, making jokes is funny, but only at the right moment."

Both children and parents emphasized that the physical therapist's insight into the developmental level of the child was very important for communication purposes and for the planning of the home program.

Parent 5 [of Child 5]: "She [the child] stated very clearly that she is ready for a next step in her development. The therapist has to be able to anticipate this next step. The books might be clear-cut, but disabled children don't always behave according to the books. For example, it was very important that she [the child] learnt to exercise in a prone position, but she did not want to do it and she got upset."

Theme 2: Sharing of Information Between Child, Parent, and Physical Therapist

Two roles were distinguished by parents and physical therapists with regard to the exchange of information about the child: the caring role of the parent and the professional role of the therapist. Children did not explicitly report on this issue. The physical

therapists underlined the importance of receiving information from children and parents related to the treatment.

Therapist 9 [from Child 9]: “When there are issues, dislikes, or other things that do not fit the ideas of child and parent, it is important to know about such issues in order to reach agreement on treatment goals and activities. I believe they should share this kind of information. I want to have an idea about the direction I should proceed in with regard to the therapy; however, if child and parent do not want to pursue that direction it does not work.”

Parents stressed their need for receiving information from the physical therapist about (small or large) events that occurred during treatment sessions. They also wanted to share their own observations at home related to treatment goals with the therapist.

Parent 5 [from Child 5]: “At home she tried to raise herself to a standing position using the rails of the bed. The therapist told me that she also tried to stand up by holding on to the other children in the treatment group. I think both are important, because everything should be according to a certain structure with her. Structure gives her a sense of security and when she feels secure she will show greater development in her motor skills.”

Although both physical therapists and parents considered sharing of information to be important, the urgency, quality, and focus of information sharing was different for parents and physical therapists. An interesting finding was that physical therapists did not share their own wishes regarding the therapeutic alliance with their clients (children and parents). These wishes seemed to be expressed mostly by the parents and only to a lesser degree by the physical therapists and children.

Theme 3: Negotiation Concerning Treatment Goals and Practical Exercises

Some parents and children stressed the importance of negotiation concerning goals and tasks of the treatment (e.g. about type and scope of home programs). They expected the therapists to determine treatment goals and coordinate the home program, but they also wanted to have a say in this process and discuss the progression of the treatment. Older children in particular preferred to negotiate about the content of their home programs. However, the negotiations often stalled because the child avoided expressing negative feelings about the treatment.

Child 6: “Well, how should I say this ... My therapist thinks I do those exercises at home, but very often I forget to do them ... I don’t like to do exercises at home. Then when I did exercise at home one time, she now thinks I always practice at home. She says that things are going very well.”

The child did not feel comfortable enough to bring such feelings into the conversation. Interestingly, the therapists did not mention the theme of negotiation. They did not seem, or seemed only slightly, aware of the concerns about relational inequality in the treatment as perceived by children and their parents. For example, when therapists noticed a problem in the therapeutic relationship, they neither reflected on this problem nor discussed the issue openly with the children and parents. The physical therapists tended to adhere to what children and parents demanded from them without initiating a discussion.

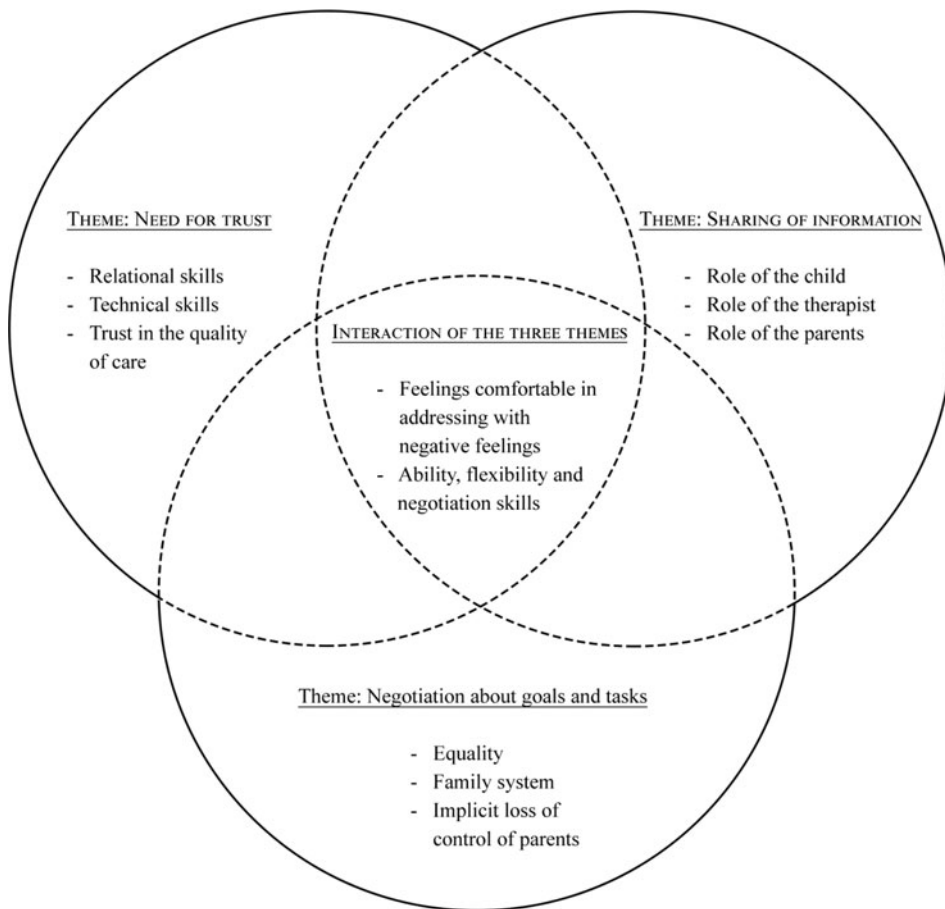


Figure 1. Therapeutic alliance between child, parents, and therapist: three themes and their interrelatedness.

Parents emphasized the importance of parental responsibility for the treatment of their child. They felt responsible for the integral functioning of their child. It seemed that these parents did not want to, or could not, entirely relinquish responsibility to the therapist. The notion of parental responsibility was not mentioned by the physical therapists. In some cases, parents felt too unempowered to be able to negotiate about the treatment. They experienced a loss of control over the situation, which detracted from their position as parents.

Parent 2 [from Child 2]: “I [Mother] understand that there are a lot of technical terms used within the field of rehabilitation, but these terms do not mean much to me as a parent. When I hear: ‘You have to pay attention to this and that ...,’ then it would be nice to get an explanation ... Look, he [the child] is our child and for us he is a normal and very nice kid ... Therefore, it sometimes feels strange when other people say things like ‘this is not good and that is not good,’ if you know what I mean.

[Becomes emotional and starts to cry [30 seconds]].

“Oh, I did not expect this would happen ... but this is the reason why I come to school less To me, he is a beautiful child. I find it really difficult that so many people are

involved with my child's treatment. To the outside world, those people are the experts, that is why I find it so difficult that we are not involved in the client meetings. Each and every one of those experts has an opinion about our child and is working with him, but we are the parents. My child has a file in which all the experts write their reflections on my child ... Therefore, I have the feeling that I am losing my child."

The interaction of the three identified themes reflects important qualities of the therapeutic alliance (Figure 1). This interaction depends on the degree of comfort of children, parents, and therapist; their feelings, positive or negative; and their flexibility and ability with regard to negotiating on the treatment goals and tasks.

Discussion

This study explored the therapeutic alliance between children, parents, and physical therapists in the context of pediatric rehabilitation. Although all participants emphasized the importance of the therapeutic alliance in pediatric physical therapy, they approached this concept from different points of view. Participants had different ideas about roles, tasks, and responsibilities within the therapeutic alliance. To children and parents, trust in the therapist's relational and technical skills was pivotal during negotiations about treatment goals and played a key role in their perception of family-centered care. The parental need for negotiation seemed to be evoked by dependency on the therapist's qualities and also by a perceived lack of control.

A recurrent finding in our study was the *willingness* of the physical therapists to be transparent in their communication and take the wishes of children and parents into account. Children expressed a need for trust and open communication and emphasized the importance of negotiation. Knowledge and skills of the therapist alone are not sufficient for parents to become more involved and empowered in the care for their child. They need to be motivated and be offered the opportunity to truly participate in the treatment of their child. In this respect, the preferences, motivation, and skills of the professionals play an important role in the empowerment and the degree of parental involvement in rehabilitation.

Parents' and therapists' assumptions about the expected roles were not always similar, and previous research has found that this aspect could form an important barrier to empowerment and shared-decision making (Joseph-Williams, Elwyn, & Edwards, 2014). Research in psychotherapy has demonstrated that clients and therapists may underreport ruptures in the treatment relationship due to a lack of awareness or feelings of uncomfortableness (Safran et al., 2011). The desire to be perceived as a "good" client has as its benefits, the avoidance of conflict and having the physical therapist on your side (Fumagalli et al., 2015). To improve the therapeutic alliance, it would help if therapists became more sensitive to the existence and influence of subtle indications of ruptures in the relationship. Furthermore, therapists should have the confidence to encourage clients to explore and express these ruptures. It is very important to attend to and repair relational ruptures in the therapeutic alliance, since this repair positively influences empowerment and relational equality (Safran & Kraus, 2014). Awareness of the expression of the experienced concerns, perceived inequality by the children and their parents, and relational ruptures in the therapeutic alliance may positively influence family-centered care in pediatric physical therapy.

The need for negotiation between child, parents, and physical therapist should be interpreted carefully. Pediatric physical therapy presents an unknown and uncertain situation to child and parents, and concerns about the future of the child can affect the emotional balance and influence cognitive coping styles (Piggot, Hocking, & Paterson, 2003). As situations become more complex, emotions may exert considerable influence on subsequent behavior (Forgas, 2012; Say & Thomson, 2003). Moreover, parental needs with regard to involvement in the treatment process vary greatly. Some parents prefer a more directive style from the therapist, while others favor shared-decision making (King, Williams, & Goldberg, 2017). If parents are to become more involved in the care for their child, parental empowerment alone will not suffice. The therapist needs to assess the preferred roles and forms of care to deliver care that is tailored to the needs of both child and parents.

Implications for Pediatric Physical Therapy and Family-Centered Care

Within pediatric physical therapy and family-centered care, optimal communication and sharing of information between child, parent, and therapist are considered to be essential (Di Rezze, Law, Eva, Pollock, & Gorter, 2014; Verma, Paterson, & Medves, 2006). Communication has two levels of meaning: a content level of meaning and a relationship level of meaning (Watzlawick, Bavelas, & Jackson, 2011). In our study, children and parents felt that the communication and social skills of the physical therapists (relationship level) were more important than their technical skills. This implies that physical therapists should pay attention to how verbal and non-verbal information is communicated. Research has shown that intonation and other types of non-verbal signals are important for the understanding of the meaning of information (Roberts & Bucksey, 2007; Safran et al., 2011).

The importance of having trust in the healthcare professional was a key finding of this study. Having trust helps parents with determining the role they wish to fulfill in the decision-making process (Mackean et al., 2005). However, in this study, physical therapists associated being a good professional more with *technical skills* than *relational trust*. This is in contrast with the view of the parents in this study, who placed more emphasis on the importance of relational trust. This finding suggests that therapists should continuously monitor this trust and pay attention to signs of discomfort, tension, or dissatisfaction concerning goals, tasks, and the therapeutic alliance. Such issues should be actively addressed by the physical therapist. This could be achieved by incorporating relational-therapeutic skills and knowledge as a professional competence in the study curriculum of (pediatric) physical therapists (Brun-Cottan, McMillian, & Hastings, 2018).

Limitations and Recommendations for Further Research

This study was conducted in a rehabilitation setting with children who had a wide variety of chronic diagnoses. Participants may have had more complex and specific needs which limits the transferability of the findings.

Two very young participants were excluded from the study. During analysis of the interviews, it became clear that reflecting on the therapeutic relationship was too complex for these children. For the future inclusion of younger children, (video) observations may be more appropriate than interviews. Further research is needed to determine from what age the therapeutic alliance can be observed.

Child, parent, and physical therapist were in a reciprocal, still ongoing, therapeutic relationship during the period the interviews were conducted. Despite the fact the interviewer was not involved in the treatment of children, the participants may have been reluctant to be completely open and/or overly critical, which in turn may have affected credibility of the study results.

Further research is needed to gain a better understanding of the underlying mechanisms that play a role in, interact with, and regulate the therapeutic alliance in pediatric physical therapy. To accommodate for the differences in complexity of the heterogeneous conditions of the participants, broader study designs are needed. Moreover, the development and the effectiveness of the training of the therapists' interpersonal skills should be further explored, as well as how recognition and handling of rupture and repair processes in the therapeutic relationship are of value in the domains of physical health care.

Conclusion

Children, parents, and physical therapists emphasized the importance of the quality of the therapeutic alliance in pediatric physical therapy. Three themes were identified: importance of trust in the physical therapist, transparency in sharing information, and negotiation concerning goals and tasks of treatment. Children expressed a need for trust, open communication, and negotiation. Parents required transparency in sharing information and willingness of the therapist to listen to their wishes. They also wanted to participate in negotiations about goals and content of the treatment.

Physical therapists understood the need for trust and open communication and showed strong willingness to develop an adequate therapeutic alliance. Nevertheless, they did not place these issues at the center of their concern, and they were also not used to reflecting on the therapeutic alliance. Because children and their parents are in a dependent relationship with the physical therapist, therapists are encouraged to find the right balance between their professional position and contribution to the relationship on the one hand, and the emotional needs of children and their parents on the other hand.

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